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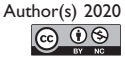

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The National Health Service's 'special measures': Cambridge – A case study

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Abstract

The United Kingdom's (UK) National Health Service (NHS) has a procedure, 'special measures', which is used to implement changes to a Trust when there are concerns about the quality of care being delivered. This case study uses the London Protocol to analyse how a plethora of factors contributed to an 'inadequate' rating and the subsequent initiation of the special measures procedure at Cambridge University Hospitals (CUH) in September 2015. External factors such as legal and political reform have a strong influence on healthcare as well as the substantial internal forces within the state-led NHS including finance, culture and management. Factors specific to CUH also had a significant role to play: the early adoption of a complete digital record system, costing over £200 m, adversely affected CUH Trust at this time and was implicated as a major factor in its inadequate performance. In addition, the Care Quality Commission (CQC) identified many other important shortcomings at CUH. The London Protocol is used to bring clarity and structure to the complexities of the Health Services Industry, both within and surrounding CUH during this period.

Keywords

Care Quality Commission, health services, improvement, management, National Health Service, special measures

Introduction

In September 2015, Cambridge University Hospitals (CUH) received an 'inadequate' rating from the Care Quality Commission (CQC),[1] resulting in the initiation of the special measures protocol. The CQC are the regulatory body of health and social care services in England. Therefore, they are responsible for recommending to NHS Improvement (previously Monitor) that an NHS Trust should be put into 'special measures'. The 'special measures' procedure is implemented when there are serious concerns regarding the quality of care being delivered at a Trust. It is designed to offer external support for improvement when it is believed that the Trust does not have sufficient management capabilities to implement the necessary changes within a reasonable time frame. Interventions typically include the appointment of an improvement director alongside appropriate partner organisations, selected for their strength in areas corresponding to the Trust's identified weaknesses. Scrutiny of monthly progress reports against action plans ensures progress is transparent. Additionally, the Trust's board and executive team will be reviewed and if required, changes will be made.[2]

CQC report findings

Out of the five broad measures assessed by the CQC, concerns were raised in four. 'Effectiveness' was deemed to require improvement, whilst 'Safety', 'Responsive' and 'Well-led' were judged inadequate at CUH. Only 'Caring' received a positive score; outstanding.[1]

Principal issues identified by the CQC report included staffing levels, financial performance, waiting times, use of IT systems and management concerns.

The 2015 CQC report was not the first sign that there was concern about the operations at CUH. Around the time of the appointment of a new CEO, in November 2012, Monitor took regulatory action at CUH.[3] Several issues, such as poor financial performance and failure to

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meet agreed healthcare targets, were common to the Monitor 2012[3] and CQC 2015[1] reports. Therefore, CUH was aware of these issues but did not, or was not able to, rectify them in the intervening three years.

The London Protocol

Analysis of the complex, intertwined events that led to CUH's decline into special measures is challenging. Evaluation through a systems-theoretical framework, the London Protocol,[4] will endeavour to bring clarity to the situation via thorough investigation into the wide range of contributory factors. The London Protocol has been widely used to investigate incidents in the field of healthcare and uses a schemata of seven sets of factors that influence clinical practice: patient, task and technology, individual staff, team, work environment, organisation and management, and institutional context factors. The factors accumulate as a series of inter-related layers with bi-directional influence until the full context of the healthcare setting is realised.

Patient factors

In this scenario, there is not an individual patient with conventionally attributable factors to analyse, since the event in question pertains to the overall performance of CUH as a Trust as opposed to a singular patient safety event. However, the dual purpose of the CQC to 'provide patients with safe, effective, compassionate, high-quality care' and 'encourage improvement' should not be overlooked. Therefore, one may hypothesise that the implementation of special measures is to facilitate this aim.

In the UK healthcare services environment there are a number of independent thinktanks, research institutions and charities which also aim to improve the quality and efficiency of healthcare organisations. One such organisation is The Dr Foster Unit at Imperial College London. Within the same timeframe as the Monitor 2012 report,[3] CUH was awarded the Dr Foster Trust of the Year[5] as well as receiving an accolade for the quantity of its research[6] and European accreditation as a comprehensive cancer centre.[7]

The Dr Foster report praised CUH for high efficiency, high quality of care and low mortality rates from a combination of 13 efficiency indices (readmission within a week, readmission within 28 days, procedures with limited clinical effectiveness, short stay admissions without diagnosis, scheduled operations which were not performed, use of day case surgery, long-stay elderly patients, long-stay surgical patients, excess bed days, outpatient rates of follow up, outpatient rates of attendance, operations not performed at the weekend and scans available at the weekend) and four mortality indicators (hospital standardized mortality ratio, summary hospital-level mortality indicator, deaths after surgery, deaths in low risk conditions).

Although the aims of Dr Foster's data-based analysis appear to be aligned with those of the CQC, the conclusions were markedly divergent suggesting incongruency in the outcomes selected for scrutinisation.

Task and technology factors

Epic. In October 2014, Addenbrooke's became the first hospital in England to deploy a fully paperless patient record system, Epic's eHospital – which was widely used in the United States of America (USA) at the time. The cost to the Trust was substantial at around £200 m[1] within the context of a typical annual budget of £707 m.[8]

According to the CQC, the Epic IT system for clinical records had diminished the Trust's ability to report, highlight and take action on patient data as well as limiting the correct prescription of medications; mistakes which could have had serious consequences if left unchecked.[1]

Cause for concern regarding Epic was also quickly identified by the Cambridgeshire and Peterborough Clinical Commissioning Group (CCG). Their report identified issues including insufficient assurance about nursing care and food in A&E, difficulty matching test results to patients as well as problems with district nurse referrals and discharge letters.[9] This raised questions of whether implementing Epic was a mistake, or, if the Trusts management had not handled the implementation satisfactorily.

Task design. An additional task factor identified was the frequent cancellation of routine operations as well as longer than target waiting times for surgery and outpatient appointments. However, CUH was one of many Trusts struggling to meet these nationally set waiting time guidelines. Nationally, in the fiscal year 2014–15, only 86.2% (target 92%) of patients were seen within the 18 weeks mandated for Referral to Treatment (RTT).[10]

Individual staff factors

CEO. The CEO of CUH in 2015 was a transplant surgeon who had worked previously in that specialty at CUH and at the nearby Royal Papworth Hospital. However, directly prior to his appointment as CEO of CUH, he had been working as CEO of Metro North Health Service, which is one of the largest health service providers in Australia. His previous experience working on the ground level at CUH and executive managerial role at Metro North Health Service made him, on paper, excellently placed for the position. His unexpected resignation,[11] a week prior to the release of the CQC report[1] as well as Sir Mike Richards, the CQC Chief

Inspector of Hospitals saying that senior management had 'lost their grip on some of the basics'[12] led to some national media outlets inculpating him in CUH's failure.[13]

Post-resignation, the CEO publicly denounced the CQC rating, calling it 'unfair and unjust' and asseverating that the reasons were known only to the CQC; the implication being that other parties would not come to the same conclusion when appraising CUH.[14]

Ten months subsequent to his resignation, he was appointed as the first Chief Clinical Information Officer (CCIO) for the NHS[15]; this is indicative of the NHS's belief in his competence despite CUH entering special measures. It could be speculated that the NHS felt that he had gained invaluable experience from the implementation of Epic.

Team factors

Disconnection between clinical divisions and the Trust's board was highlighted in the CQC report[1] pertaining to the communication of important information. It was found that certain fundamental principles such as the perceived purpose of the hospital were not shared between the Board and the clinicians diminishing the team's ability to function.

Work environmental factors

Staffing. The CQC Report found that perpetual staffing shortages at CUH led to commonplace use of agency workers and the movement of employees to unfamiliar departments. In the Rosie Maternity Unit, the midwife-to-birth ratio was so low that care guidelines were not being met. A similar finding was noted in the Intensive Care Unit.[1]

Staffing ratios, patient safety, quality of care and leadership in the NHS were brought to the fore after the publication of the Francis Report[16] in 2013. This report was commissioned following appalling patient neglect at Mid Staffordshire Trust and investigated as to why none of the regulatory organisations had identified the problems sooner. One of the key recommendations was that the National Institute for Clinical Excellence (NICE) should use evidence-based tools to determine staffing needs for the NHS. CUH was not abiding by these guidelines. However, these recommendations are difficult to fulfil in the context of staff shortages and funding constraints.

Furthermore, support systems to protect staff were deemed insufficient and satisfaction amongst the staff surveyed was poor.[1]

Maintenance. High levels of nitrous oxide in the air was discovered in the Rosie Maternity Unit, repeated exposure to which posed an increased risk of respiratory problems to staff. Senior managers had allegedly been aware of this for the last two years but had taken no discernible action despite this being one of the easier problems to rectify.[1]

Organisational and management factors

Hospital aims. CUH has strong ties with the University of Cambridge and hosts the University's clinical school. It is the most significant teaching hospital in the region. The two key purposes of a teaching hospital are to provide care to the population and to educate students. However, it could also be considered to be a district general hospital (DGH) since it is the major health care facility in the region with a large number of intensive care beds and A&E facilities. Furthermore, CUH may be considered a specialist centre given that it hosts the region's tertiary transplant and cancer services. For example, it is one of only four centres in the UK to offer intestinal transplants.

This led to conflicting priorities for managers since the three types of hospital serve discordant purposes and was identified as a cause for concern about communication between the board and the clinical divisions with the CEO describing CUH as an academic teaching hospital and the clinical directors believing it to be a DGH. There is a different emphasis on resource allocation between the types of hospital which would create inter-departmental struggles for managers and there are likely to be nuances between the most appropriate management and financing structures.

Management and bureaucracy. Management at CUH specifically, was identified as problematic by Sir Mike Richards, the CQC Chief Inspector of Hospitals.[12] However, the Rose report,[17] conducted to review management in the NHS, identified that there was an endemic problem throughout the NHS. The report stated that there was 'insufficient management and leadership capability to deal effectively with the scale of the challenges' associated with the difficulties within the NHS. There was no career development structure to help clinicians move into leadership roles. Overall, the review pointed to the fact that the NHS needs to do more to either recruit or develop management talent. Additionally at CUH, unification between the board and clinical divisions was recognised as a concern.[1]

Bureaucracy has been prominent in the NHS. The Rose report recognised the burden of data demands by regulators and proposed rationalisation and harmonisation of reporting to minimise distracting staff from patient care. Lord Rose also suggested a clearer system of rational appraisal implying that he found regulatory measures to be either ambiguous or not correctly targeted. Education of both the regulatory bodies and the

healthcare leaders would enable a better understanding of each other's goals and a more efficient system.

Financial constraints. The cost of Epic's eHospital, around £200 m,[1] was suggested as a contributory factor to CUH's budget deficit.

Institutional context factors

CUH within the NHS. In 2015, CUH was one of 155 NHS Trusts in the UK. As a small unit in a much larger healthcare system, CUH was influenced by the culture, practices and regulations of NHS England which acted as an overarching guiding body. Therefore, it is important to consider the remit of both Trust management and NHS England, alongside the UK healthcare environment's constraints, when identifying the cause of the problems identified at CUH.

International regard. The NHS was well regarded internationally at the time. The Commonwealth Fund ranked the NHS most highly out of 11 countries on the ability to access care out-of-hours. The NHS also had the lowest incidence of medical, medication or lab test errors, the lowest barriers due to cost, the best sharing of important patient information between providers and best management of chronic care. Therefore, despite flaws in the system and a lower level of funding relative to GDP than comparable countries (9.3% compared to 11.6% in France and 11.3% in Germany), the NHS was providing a good service.[18]

Funding. At CUH, the financial deficit was identified to be an issue.[1] However, as elicited by The King's Fund,[19] in 2015–16, over 65% of NHS Trusts were in deficit. As identified by the NHS themselves in 'The NHS belongs to the people: A call to action' campaign,[20] society had rising expectations, the population was ageing, and chronic conditions were becoming increasingly prevalent. These factors were causing rising demand and increased pressure on services that had not been matched by budget expansion, forcing many Trusts into deficit.

The report suggests that 'to meet these challenges, the NHS needs to find new ways of delivering health and care that are more productive and better suited to what patients and the public will need in the future.' Is a fundamental rethink of how healthcare in the UK works required?

Legal and political reform. There were two amendments to the law pertaining to the structure of healthcare after 2010 that had a considerable impact upon the health service environment within which CUH operated.

The Health and Social Care Act 2012[21] changed how services were commissioned; affecting nearly all aspects of healthcare. The responsibility for care was decentralised and clinicians were given responsibility for the health of their local population. It was first time since the inception of the NHS that this responsibility would not lie with the Health Secretary, with the aim of increased motivation and ability at a local level to prevent failings. This focus on devolved care was supported by the Marmot Review[22] which quantified the differences in health conditions across the UK in number and severity. The second aim was to increase efficiency and reduce costs within the existing patient safety regulatory framework by creating a competitive environment in the NHS for the first time.

The Care Act 2014[23] further shaped the social care environment. This made service provision from local authorities fairer by setting a national eligibility level for financial means testing as opposed to the previous variable regional levels. The changes loosely conformed to those proposed by the Dilnot report,[24] which was commissioned to examine the fairest and most sustainable way to fund social care. Despite the changes, social care was still posing a major challenge to Hospital Trusts generally at the time of the CUH CQC report, in particular hindering patient discharges.

Conclusion

Allocating blame to a specific cause for the failings at CUH would be near impossible and inaccurate. The important message to remember when considering the lesson to be learnt from CUH is the complex multifactorial nature of the performance of large scale healthcare organisations; a variety of factors coalesced to result in the CQC's inadequate rating of CUH.

The findings detailed by the CQC[1] were mostly specific valid concerns which, if improved, would confer benefit to patients in the form of higher quality services. However, there are evidently some complexities surrounding the regulatory criteria since this report and other critiquing bodies gave vastly differing viewpoints on CUH. CUH had good outcomes, so one could argue that inadequate was an inappropriate term to brand CUH with.

The main factors specific to CUH that could have contributed to its failure included the decision to implement Epic which adversely affected patient safety and finances, its conflicted purpose and the quality of its leadership. There was much criticism, individually of the CEO as well as a general disconnection of management from clinical divisions that could have contributed to why the Trust was unable to perform in the UK health services industry whereas many other Trusts succeeded in the sense that they were not deemed inadequate and did not incur a financial deficit.

There were factors out of the control of CUH. At a broader level, the UK healthcare environment contributed to the problems at CUH in many ways including the financial constraints, increasing population needs, poor leadership in the NHS as well as having to adapt to many politico-legal reforms.

The impact of using the terminology, 'special measures', on the faith that patients place in their health services and on the morale of the hard-working staff at the Trust should not be underestimated.

CUH was taken out of special measures in January 2017.

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